Supreme Court, U.S.
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No. 00-1021

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN and STATE OF ILLINOIS,

Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR RESPONDENT DEBRA C. MORAN

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QUESTIONS PRESENTED

Whether Section 4-10 of the Illinois Health Maintenance Organization ("HMO") Act, 215 Ill. Comp. Stat. 125/1 through 6 (2001), which requires "independent review" of certain decisions by HMO insurers, "relates to" an ERISA benefits plan within the meaning of ERISA's preemption provision, 29 U.S.C. § 1144(a), in instances where the HMO insurance is sold to an ERISA plan or plan sponsor to provide plan benefits.

Whether ERISA's saving clause for state laws that regulate insurance, 29 U.S.C. § 1144(b)(2)(A), saves the Illinois statute from any preemption when the HMO insurance is sold to an ERISA benefit plan or plan sponsor.

Whether, regardless of ERISA preemption, independent review is required in this case because the HMO insurance policy voluntarily incorporated Section 4-10 of the Illinois HMO Act as a policy term.

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STATEMENT OF THE CASE

Respondent Debra C. Moran ("Moran") suffered from radial brachial plexopathy and thoracic outlet syndrome, two combined, painful and debilitating conditions in her right shoulder. She sought treatment from her HMO insurer's designated "primary care" physician, Dr. LaMarre, within the HMO insurance network of petitioner, Rush Prudential HMO, Inc. ("Rush"). Pet. App. 3a-4a. This HMO insurance coverage was purchased and provided as an employee benefit through Moran's husband's employer. The HMO coverage was a fully insured benefit under the plan established by the employer. Pet. App. 3a.[1]

Moran was treated conservatively and referred within network for specialist consultation. Pet. App. 4a. She did not improve. When Dr. LaMarre could offer no further in-network treatment, Moran sought further treatment herself outside the network. R.58, 12(n), ¶¶1(g)-(m).[2] She located a

1. Rush and its amicus attempt to obscure the basic distinction between Rush as an HMO insurer and the employer's ERISA-covered benefit plan. Their briefs equate the two and even refer to Rush's insurance certificate as the "plan." *E.g.*, Pet. Br. 4, 8, 13, 15, 17; Amicus Br. 2, 7, 26. In fact, Debra Moran's husband's employer provided an employee welfare plan benefit to its employees and their spouses pursuant to which the plan paid for covered medical expenses. Pet. App. 3a. That employer contracted with Rush to fully insure plan benefits through the means of HMO insurance. Pet. App. 3a.; R.38, Ex. A, p. 7. Rush admits it was licensed to do business as an insurer in Illinois and that the provisions of the Illinois HMO Act, including "Section 4-10," the independent review law, applied to it. R.58, 12(n), ¶¶ 45-46. Rush provides no evidence that its insurance certificate is an ERISA "plan," and the certificate in fact lacks many requisite elements of an ERISA plan. *See infra*, pp. 16-18.

2. Rush states that "[Dr.] LaMarre began to treat Moran with physiotherapy. While she [Moran] was still undergoing this treatment, (Cont'd)

surgeon in Virginia, Dr. Terzis, who specializes in treating this rare combination of conditions, and she sought Rush's approval to see Dr. Terzis for a specialty consultation. Rush refused. Pet. App. 4a. Moran made and paid for the trip and consultation herself. Dr. Terzis recommended surgery, including rib resection, scalenectomy and, upon surgical exploration, microneurolysis if necessary. She told Moran that she had successfully treated these conditions before; she had a high success rate; and there was a low chance of a significant adverse outcome. Pet. App. 4a; R.58, 12(n), ¶1(n); R.75, 12(n), Suppl. ¶¶68, 71.

Moran requested Rush's approval for Dr. Terzis's proposed out-of-network surgery. Instead, Dr. LaMarre requested that she see some additional in-network specialists. She did. Dr. Dieter recommended the conservative treatment of rib resection and scalenectomy only, and told Moran she had *a one-third chance of significant adverse outcome, including potential paralysis or loss of limb*. Pet. App. 5a; R.58, 12(n), ¶1(n)-(g). Dr. Warren could reach no definitive conclusion or recommendation.[3] *Id.* In view of the significant potential adverse outcome presented by Dr. Dieter's proposed surgery, Moran wanted the safer surgery proposed by Dr. Terzis. Pet. App. 5a; R.58, 12(n), ¶6.

(Cont'd)
Moran sought the opinion of Dr. Julia Terzis, an out of network surgeon in Virginia." Pet. Br. 9. In fact, Moran sought Dr. Terzis's advice because Dr. LaMarre's conservative treatment was not working, her symptoms were progressively worsening, and Dr. LaMarre could offer no other treatment option. R.58, 12(n), ¶1(g)-(m).

3. Drs. Warren and Dieter were in-network affiliated physicians with Rush. Prior to Moran's surgery, no independent physician reviewed Rush's denial of her request for coverage for that surgery. R.58, 12(m), Response, ¶9.

Dr. LaMarre recommended approval of Dr. Terzis's proposed surgery because Moran would be "best served" by having Dr. Terzis's procedure performed. Pet. App. 5a. CENTRA's medical director, a physician, on behalf of the organization responsible for physician services under Rush's insurance contract, also approved Dr. Terzis's proposed services as medically necessary. R.58, 12(n), ¶1(s). Notwithstanding those recommendations, Rush refused to approve the treatment. This refusal was based solely on the reason that it was out of network. Pet. App. 5a. Moran appealed the denial under Rush's insurance contract guidelines. Pet. App. 5a. Rush still refused to approve the proposed treatment, now claiming it was not "medically necessary" because there purportedly was no peer review evidence of the procedure's safety and efficacy, and because Dr. Terzis supposedly made no showing of its successful use in patients without direct trauma to the shoulder. R.58, Exhibits (d)-(f).[4] After exhausting the initial review procedures under the insurance contract with Rush, Moran requested that Rush provide her with an independent review of the medical necessity of the proposed treatment as required by the Illinois HMO Act. Pet. App. 6a. Rush refused to provide independent review under the Illinois statute, claiming review of its medical necessity decision as an insurer was preempted by ERISA. R.1.[5]

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4. There is no evidence that Rush required any such showings for the in-network surgery proposed by Dr. Dieter.

5. Rush states that:

> having exhausted the various review procedures provided *in the benefit plan*, without obtaining a favorable ruling on medical necessity, Moran could have pursued the remedy afforded by ERISA. . . . In such an action, Rush's determination pursuant to *plan* procedures that the Terzis surgery was not medically necessary should be set aside

(Cont'd)

Moran filed a suit for declaratory judgment in the Circuit Court of Cook County, seeking appointment of an independent review physician and enforcement of the Illinois independent review law. Pet. App. 7a. She also sought a temporary restraining order to enforce application of that law because her condition was worsening and she was in need of immediate medical treatment. R.1, Ex. B. Rush removed to Federal court on the basis of complete preemption under ERISA. Pet. App. 7a.

After that removal, in early February 1998, because Moran's pain and disability were increasing, she and her husband borrowed money from their 401(k) retirement plans, took personal loans, and Moran had the surgery performed by Dr. Terzis. The surgery was successful, and Moran is now pain free and fully functional. R.58, 12(n), ¶¶3-4.

Dr. Terzis testified that upon surgical exploration, she found significant nerve pathology. She concluded that Moran needed microneurolysis and Dr. Terzis performed it. R.75, ¶¶75-76 and Ex. C. Dr. Terzis concluded that Moran would probably have suffered an adverse outcome and less successful clinical results had Dr. Terzis not performed the microneurolysis when she did. R.75, ¶77.

(Cont'd)

> only if the court — applying standards developed under ERISA's body of federal common law — determined that it constituted an abuse of discretion.

Pet. Br. 10 (emphasis added). This is not a statement of any "fact" below. Rush is not the "plan." It is an insurer of one benefit — health coverage — that is provided by the plan. Pet. App. 3a. Moreover, Moran had not yet exhausted the review procedures of Rush's *insurance contract* because that contract expressly adopted Illinois law, which required independent review (R.38, Ex. A, p. 34). *See infra* at 46-48.

Moran moved to remand her lawsuit to state court on the basis that her complaint sought enforcement of a state statute regulating insurance and thus was saved from ERISA preemption. Pet. App. 7a. The district court granted the motion and remanded the case in June, 1998 on the basis that any potential preemption did not provide an independent basis for federal jurisdiction. Pet. App. 7a.

The state court granted Moran's motion for judgment on the pleadings in part, finding the independent review portion of the Illinois law not preempted by ERISA, and ordering immediate independent review. Pet. App. 7a. Pursuant to the state court's order, the parties agreed on Dr. Dellon at John Hopkins University as the independent reviewer.

Rush states that the independent review physician "concluded that the surgery was medically necessary, while noting that he would have used a less intrusive and less time consuming procedure." Pet. Br. p. 11. In fact, Dr. Dellon's independent review report found in pertinent part:

> Based on Dr. Terzis's intra operative reporting, what she did was appropriate to C5, 6, 7, 8 and T-1 cords fibrous roots. Based upon the work reviewed, Moran had all the indications and therefore the medical necessity to carry out a supra clavicular brachial plexus neurolysis, including microneurolysis and removal of the first rib as done.

R.38, Ex. G. Dr. Dellon also noted that "based on Moran's preoperative medical record, I would have done the same type of surgery that Dr. Terzis performed." *Id.* He also concluded that it is the prevailing opinion within the appropriate specialties that microneurolysis is safe and

effective for its intended use on thoracic outlet syndrome patients with Moran's medical history, and "it is the opinion of those people who do significant peripheral nerve surgery that failure to remove scar tissue from around nerves or nerve roots would adversely affect the patient's medical condition." *Id.* He concluded that:

> [I]f I had been the treating physician for Debra Moran, I would have done the same operation that Dr. Terzis undertook, and I believe that most surgeons experienced with peripheral nerve surgery would have done so. The surgery she did and the approach she took minimized the risk of injury to the intercostal brachial nerve, the possibility of pneumothorax, damage to the subclavian artery and vein and direct damage to nerve roots, all of which are well-known complications in the transaxillary approach. Furthermore, the transaxillary approach has a high failure rate with subsequent surgery being required through a supra clavicular approach.

Id.

Despite the results of this independent review, Rush refused to reimburse Moran for the money she spent to obtain the surgery, hospitalization, and follow-up care needed to repair her shoulder. Pet. App. 8a. Moran filed her first amended complaint which prayed for an order that Rush pay for the expenses of the surgery. Pet. App. 8a. Rush removed again. Pet. App. 8a.

Moran again moved to remand. Pet. App. 8a. The district court denied remand, now concluding the Illinois independent review law does not regulate insurance and is not saved from ERISA preemption. R.37. The court refused to reconsider

based on this Court's decision in *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999), and ruled that the deemer clause applied, 29 U.S.C. § 1144(b)(2)(B), thereby avoiding the effect of the insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), even though this was a fully insured plan. Pet. App. 8a-9a.

Moran filed a second amended complaint, adding in the alternative counts under ERISA for breach of contract and violation of the Illinois HMO Act as incorporated into the Rush insurance contract by its terms, and for breach of fiduciary duty. These counts sought reimbursement for the money she paid to get treatment, along with prejudgment interest, attorneys' fees and costs. Pet. App. 9a-10a.

Rush admitted it is a licensed Illinois HMO providing medical services to patients in Illinois and that the provisions of the Illinois HMO Act, including Section 4-10, apply to it. R.58, 12(n), ¶¶45-46. Rush's HMO insurance policy here specifically provided:

> If the provisions of this certificate do not conform to the requirements of any state or federal law that applies to this certificate, the certificate is automatically changed to conform with the requirements of that law.

R.38, Ex. A, p. 34. Rush conceded below that if it specifically incorporated the Illinois HMO Act into its policy, Section 4-10 would apply despite ERISA, and that it had no refuge under ERISA if the independent reviewer found medical necessity. R.33, Ex. I, pp. 15-16. However, the district court granted Rush's motion for summary judgment and denied Moran's cross-motion, ruling that Section 4-10 was preempted by ERISA. Pet. App. 10a.

On the motions for summary judgment, Moran provided numerous facts relating to the alternative count for breach of fiduciary duty. R.58, R.75-76. The HMO administrator who denied coverage admitted that among all of the proposed surgeries for Moran, there was no prevailing opinion as to whether any particular surgery was safer and more effective than any other, and he admitted that Dr. Terzis's surgery was one of the possible approaches. R.58, 12(n), ¶22. He refused to accept the independent reviewer's opinion that the length of time of surgery cannot *per se* be related to medical necessity or choice of type of operation. R.58, 12(n), ¶49. He understood that microneurolysis was safe and effective but still denied coverage. R.58, 12(n), ¶51. He understood the independent reviewer believed it is the opinion of those people who do significant peripheral nerve surgery that failure to remove scar tissue around nerves or nerve roots would adversely affect the patient's medical condition, but denied coverage because he claimed there was no evidence that the failure to have the nerve surgery and to remove the scar tissue would adversely affect Moran's medical condition. He understood also the reviewer's statement that "based on Dr. Terzis's intra operative reporting, what she did was appropriate to C-5, 6, 7, 8 and T-1 cords fibrous roots," but nevertheless denied coverage claiming there was no evidence the procedure was safe and effective for its intended use. R.58, 12(n), ¶¶53-54; Ex. G.

Rush tells this Court that "after reviewing Dr. Dellon's report and reports from three other physicians reaching the opposite conclusion, Rush again denied Moran's claim on the ground that the surgery was not medically necessary." Pet. Br. p. 11. Two of the surgeons were affiliated with Rush and admittedly had no expertise in the area. Pet. App. 6a. Rush did have a third physician review the surgery on an *ex parte* basis. Pet. App. 6a. At the time of Rush's second denial it had five opinions: the opinion of its own primary

care physician that Moran should have Dr. Terzis's surgery; the opinion of the medical director of CENTRA, its physician services provider, that Dr. Terzis's surgery was medically necessary; Dr. Terzis's opinion that the pathology present confirmed it was indicated and necessary; Dr. Dellon's "independent review" opinion that the successful surgery was medically necessary; and the opinion of its own hired physician obtained *ex parte*. Rush chose its hired doctor's opinion without explanation. R.58, 12(n), ¶22.

On appeal, the Seventh Circuit reversed, holding that Section 4-10 is not preempted by ERISA and that Moran was entitled to judgment because the state-mandated independent review determined her surgery was medically necessary. Pet. App. 1a-24a. Holding that the district court should be reversed on that basis alone, the court of appeals did not reach Moran's appeal of summary judgment on her breach of fiduciary duty claim. *Id.*

SUMMARY OF ARGUMENT

I. An HMO insurer's "medical necessity" decisions should be decided on an objective basis because insurers have an inherent self-interest in denying coverage. Independent review provides fair, effective and objective review. Rush chose to operate its HMO insurance business in Illinois subject to Illinois state insurance regulations, including the Illinois independent review law. Illinois regulates all HMO insurers in Illinois, regardless of the identity of the insured, by requiring independent review of disputed medical necessity decisions.

II. The Illinois independent review law is not preempted by ERISA because it regulates the HMO insurance contract, not the employee benefit plan. Rush fails to meet its burden of proof on the affirmative defense of preemption. The Illinois

law does not "relate to" an ERISA plan because it does not "refer to" such a plan, it does not act immediately and exclusively upon an ERISA plan, and the existence of an ERISA plan is not essential to the law's operation. Moreover, the Illinois law does not have "a significant connection with" an ERISA plan because it does not dictate the choices an ERISA plan makes. Preemption does not occur if the state law has only a remote or peripheral connection with covered plans. That is the case here. The statute does not compel an ERISA plan to do anything. Rather, independent review is required for all HMO insurance, regardless whether the purchaser of the insurance is an ERISA plan or anyone else, and an ERISA plan (or plan sponsor) merely makes a decision whether or not to buy that insurance.

III. In any event, the Illinois law "regulates insurance" within the meaning of ERISA's saving clause and is saved from preemption. The Illinois law meets all of the relevant factors for determining whether it "regulates insurance" within the meaning of the saving clause. First, it regulates insurance as a matter of common sense, because it is by its terms directed specifically at the insurance industry and is applicable only to HMO insurance contracts. The Illinois law does not just have an impact on the insurance industry, it is specifically aimed at it. This conclusion is consistent with Illinois and Federal law that HMOs are insurers and with this Court's precedent, as well as with the statutory history of the Federal HMO Act and ERISA.

Second, the Illinois law also meets the McCarran-Ferguson factors for determining whether a regulation fits the "business of insurance." The statute mandates a contract term between the HMO and its policyholders and insureds, and is integral to the insurer/insured relationship. Thus, the law meets at least two of the McCarran-Ferguson factors. It also operates to spread risk, acting on an individual basis just like the California notice-prejudice rule this Court found not preempted in *UNUM*.

Application of the Illinois insurance law is consistent with the Court's decisions permitting direct State regulation of insurance voluntarily purchased by ERISA plans and sponsors, including both substantive and procedural insurance requirements. Further, any effect the law may have on cost or uniformity is irrelevant and not a basis for avoiding the saving clause, as any such effect is the result of Congress' decision to save local insurance regulation.

IV. The Illinois insurance law does not substantively conflict with ERISA. Rush fails to meet its burden of showing conflict and fails to overcome the strong presumption that Congress did not intend to supersede state health and insurance regulation.

ERISA, on its face, permits plan sponsors, insurers selling insurance to ERISA plans and sponsors, and States to supplement the minimum requirements for claims procedures established by ERISA. Moreover, the Department of Labor's implementing regulations (authorized by ERISA) confirm that ERISA's claims procedures set minimums and that they may be supplemented by state insurance regulation, including, specifically, state external review procedures.

As contemplated by ERISA, a beneficiary may prevail on her claim for benefits under independent review or at any other stage of an administrative claims procedure. If the beneficiary does prevail at any stage, the administrative process is then complete. At the same time, nothing in Illinois law precludes further action under ERISA's enforcement scheme if the claim is denied under independent review. It does not conflict with ERISA.

Consistent with this Court's decisions, the Illinois law can be enforced as a mandated contract term through ERISA's civil enforcement provision. The Illinois law does not put

Illinois HMO insurers in the position of choosing whether to follow their obligations under state or federal law; they are obligated to comply with both. Thus, the Illinois law is not preempted because it operates as a state insurance law in conjunction with — not in opposition to — ERISA's civil enforcement scheme. In *UNUM*, this Court rejected an ERISA insurer's argument that its policy language displaced state insurance regulation, saying the argument made "scant sense," because it would render States powerless to regulate insurance companies that sell insurance to or for ERISA plans. The insurer could displace State regulations simply by inserting a contrary term in the insurance contract, thereby writing the saving clause out of ERISA.

V. Even if the Illinois law were not enforceable under the ERISA enforcement statute, that would not mean it is not enforceable at all. Rather, if the Illinois statute cannot be enforced through ERISA, it is enforceable under state law. ERISA does not preempt state law claims based on wrongs for which it provides no remedy.

VI. Independent of ERISA's saving clause for state laws that regulate insurance, the Illinois law applies in this case because, by its express terms, Rush's insurance policy voluntarily incorporates it as a term of the insurance coverage. The meaning of the terms of written documents is a matter of the parties' intent. As the HMO policy expressly incorporates state law governing HMO insurance policies, the Illinois independent review provision applies by force of the terms of the HMO policy itself.

VII. If the Court reversed the court of appeals' decision finding no preemption, then Moran's appeal on her breach of fiduciary duty claim must be decided because the Seventh Circuit did not reach that issue. The record demonstrates a question of fact which requires remand to determine the breach of fiduciary duty claim.

ARGUMENT

I. Introduction

The essence of the HMO's promise to insurance consumers who choose its product (including employers and their employees) is that, except for certain specified exclusions, the HMO will cover all treatment that is "medically necessary." Only when the insured becomes a patient does she have occasion to ask what is "medically necessary." It is reasonable for the insured to believe, as Debra Moran believed, that "medical necessity" is decided on an objective basis. In the vast majority of cases, the primary physician and the HMO's insurance administrator agree on medical necessity. Only when, as here, they disagree, does Illinois require an objective, independent third-party review to remove the HMO's inherent financial motive to deny care, and thus protect both the well-being of the insured patient and the integrity of the medical decision-making process.

This case capsulizes the controversy in managed health care about the need for independent review of insurance determinations regarding patient treatment. Rush's "medical necessity" insurance decision here resulted from self-interest and illustrates the danger in having such a determination made by a company standing to gain by it: the arbitrary denial of appropriate, needed medical care. Fortunately, Debra Moran was able to borrow from her future to obtain the needed treatment and avert catastrophe. Unfortunately, Rush refused to abide by Illinois law to provide Debra Moran the insurance coverage to which she was entitled. Rush put its financial interests ahead of Moran's need to retain the use of her arm. Illinois requires an independent determination under these circumstances. Rush agreed to provide it. Federal law does not interfere with this traditional state health and insurance regulation.

Rush does not attack the process of independent review *per se*, but says ERISA precludes the States from requiring it. Rush's own amicus has urged the HMO industry to provide independent review; industry leaders have agreed to give it; and, as noted by the National Association of Insurance Commissioners ("NAIC"), independent review "is heralded as being a fair, impartial and usually expeditious way to resolve disputes." NAIC Brief in Support of Certiorari, p. 7. State independent review laws are intended to improve the quality of care provided and consumer insureds benefit from the availability of an independent, unbiased review of a health insurer's decision.

One basic premise underlies all the briefs filed in support of Debra Moran: she should be able to enforce the Illinois independent review law and obtain recovery for the costs she incurred. Her attempt to do so was cut short by a now-common HMO insurer tactic — removal to federal court and assertion of ERISA preemption. The Court can and should put an end to such tactics. The Court should hold that ERISA does not preempt Section 4-10 because it does not "relate to" ERISA-covered benefit plans and because, in any event, it is a state law that regulates insurance (and not the plan that purchases it).

Rush has the heavy burden of establishing that a state law which on its face regulates insurance is nevertheless preempted, despite ERISA's saving clause. Instead of carrying that burden, Rush and its amicus decry the administrative burdens they claim independent review would impose. But, as this Court has repeatedly held, the cost of state insurance regulation is irrelevant in view of the saving clause. In any event, Rush provided *no evidence* below about "administrative" burdens of independent review, and there is no evidence before the Court to show independent review

would unduly increase HMO costs in Illinois.[6] Rush's real goal is to maintain exclusive control of the determination of "medical necessity," by denying to the State of Illinois its historic right to regulate the activities of insurers and protect consumers from unreasonable denials of coverage.

This Court has long noted the "continuing necessity in our Federal system for accommodating the two great powers it comprehends" — that is, "the paramount national authority over commerce" and "the states' reserved powers touching the same or related subject matter." *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 412-13 (1946). This case is another in the long line of cases addressing that dichotomy. The specific issue here is whether the Illinois legislature can regulate HMO insurers operating in Illinois when they insure ERISA plan benefits, by requiring independent review of disputed medical necessity decisions. Debra Moran says "yes," because nothing in ERISA requires that "medical necessity" decisions must be finally made by an HMO insurer for health insurance sold to an ERISA benefit plan. Rather, ERISA specifically permits such traditional state regulation of insurance through the saving clause. 29 U.S.C. § 1144(b)(2)(A).

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6. According to a 1998 report by the General Accounting Office, an industry review reported that "external review would cost no more than $.07 per enrollee per month. . . . [T]he estimated cost is small because, in practice, only a small number of appeals reach the external review process. Once the cost is divided among the total number of enrollees, the cost per enroliee is very low." *United States General Accounting Office*, HMO Complaints and Appeals, GAO/HEHS-98-119 (May 12, 1998). Furthermore, according to Rush's amicus, American Association of Health Plan ("AAHP"), in States that have independent review statutes and have reported data, "one appeal is filed for every 14,000 enrollees." AAHP, "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers With Solutions" (April, 2001), available on line at www.aahp.org.

Rush chose to operate as an insurer in Illinois knowing about the Illinois HMO Act and Section 4-10 in particular. Rush also specifically provided coverage for "medically necessary" services, with knowledge that Illinois law required independent review of medical necessity decisions, but Rush gave no notice to employers purchasing its insurance or their covered employees that Rush would not follow that law. To the contrary, Rush expressly incorporated Illinois law as part of the policy. Moreover, the statute applies to all HMO insurance, and thereby to anyone who purchases that insurance, whether they are part of an ERISA plan or not. Rush is trying to avoid its legal obligation under state insurance law simply because it contracted with an ERISA plan. That is not ERISA's intent.

II. The Illinois Independent Review Law Is Not Preempted By ERISA Because It Does Not "Relate To" ERISA-Covered Benefit Plans.

A. Rush and its contract for HMO insurance are not the employee benefit plan governed by ERISA.

Rush never makes clear the fundamental difference between: (1) Rush (the HMO) and its contract to provide HMO insurance; and (2) the employee benefit plan established by Ms. Moran's spouse's employer and governed by ERISA. Rather, Rush and its amicus try mightily to confuse and obscure this basic distinction by implicitly equating the HMO and its services with the ERISA plan. *See, e.g.*, Pet. Br. 4, 8, 17; Amicus Br. 2, 4 n.2, 26. Rush even refers to (and quotes) its HMO member's "Certificate" as the "ERISA plan." Pet. Br. 13.[7]

7. Rush quotes the dissenting opinion's argument that:

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the [Illinois] statute is and must

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In fact, Rush, the party which bears the burden of proof on its affirmative defense of preemption, R.1, Answer, p.3, presented *no evidence* that it, its HMO insurance contract or services, or its Member Certificate, is an ERISA benefit plan. Furthermore, Rush and its insurance contract plainly are *not* the ERISA plan.

Rush's Member Certificate says it together with "the Group Contract" are a contract between Rush and "the Employer." R.38, Ex. A, p.7. The Certificate expressly distinguishes the "Group Contract" (and HMO "Coverage" under that Contract) from the "Employer's Health Benefit Plan." R.38, Ex. A, p. 8. (definitions); R. 38, Ex. A, p. 10 (employee may elect between Rush HMO coverage and other health care coverage provided by the employer's benefit plan). Furthermore, the Certificate lacks basic requirements for an ERISA plan[8] and summary plan description.[9]

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> be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy.

Pet. Br. 16. This argument also misunderstands the difference between the HMO insurance policy (which Rush sells) and the ERISA plan established by the employer. The Illinois statute is not "incorporated into the plan." Rather, it is "incorporated into" the insurance policy that the plan or plan sponsor purchased. The HMO insurance policy is "enforceable in federal court" because it is the funding vehicle for delivering the benefits promised by the ERISA plan and 29 U.S.C. § 1132(a) provides plan participants and beneficiaries with causes of action to recover benefits due under the plan and to enforce the terms of the plan. The statute does not limit the potential defendants in such suits to plans and plan sponsors.

8. For example, every ERISA plan must "provide a procedure for amending such plan. . . ." 29 U.S.C. § 1102(b)(3).

9. For example, a summary plan description must contain "the employer identification number (EIN)," 29 C.F.R. § 2520.102-3(c);

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Two related points ignored by Rush are also highly significant to the ERISA preemption issue. First, the Illinois HMO statute, including Section 4-10, applies to *all* HMO insurance and consumers, not merely to the insurance provided to ERISA plans and their beneficiaries. The Illinois statute applies equally to HMO insurance provided to employee benefit plans not covered by ERISA (*e.g.* church plans, government plans) and under contracts with individual persons.

Second, ERISA-covered benefit plans have alternatives to HMOs in providing health and medical benefits. Information provided by Rush indicates that 40% of the coverage provided by ERISA plans is done through self-insurance. Pet. Br. 27 n.7. Traditional fee-for-service insurance, PPOs and other non-HMO alternatives are also available, none of which are subject to the Illinois independent review statute for HMOs.

B. Under this Court's general preemption analysis, the Illinois law does not "refer to" or have a "significant connection with" ERISA plans.

ERISA provides that it "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In its recent preemption decisions, the Court's analysis has started with the presumption "that the historic police powers of the states

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the "name of the person designated as agent for service of legal process, and the address at which process may be served on such person," *id.* § 2520.102-3(f); and the "statement of ERISA rights authorized by section 104(c) of the Act", *id.* § 2520.102-3(t)(1). In fact, of 16 applicable requirements for an ERISA summary plan description under the governing regulation, Rush's Member Certificates lacks at least nine. *Compare* 29 C.F.R. § 2520.102-3 *with* R.38, Ex. A, pp. 1-41 and exhibits.

were not to be superseded by the federal act unless that was the clear and manifest purpose of Congress." *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 653-655 (1995). Following *Travelers*, the Court in *California Div. of Labor Standards Enforcement v. Dillingham Constr. Co.*, 519 U.S. 316 (1997), held that there must be a clear indication in ERISA or its legislative history of an intent on the part of Congress to preempt a law in a traditionally state-regulated area. 519 U.S. 331-32.

A state law only "relates to" an ERISA plan if it refers to or has significant connection with an ERISA plan. A law "refers to" an ERISA plan when a "state's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325. In order to determine whether the law has a significant connection to an ERISA plan, a court must examine ERISA's objectives to determine the type of state laws Congress would not have intended to preempt and the effect the state law has on ERISA plans. *Id.* If the state law merely "alters the incentives" for an ERISA plan, "but does not dictate the choices," then the law is not sufficiently connected with an ERISA plan to require preemption. *Id.* at 334. The Court made clear that ERISA preemption does not encompass state regulation of health care merely because it has an economic effect on an ERISA plan:

> If ERISA were concerned with any state action — such as medical care quality standards or hospital workplace regulations — that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's preemptive reach.

Dillingham, 519 U.S. at 329.

In *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997), the Court emphasized its view of the scope of ERISA preemption, noting that the Second Circuit had failed to "give proper weight to *Travelers'* rejection of a strictly literal reading of [the preemption clause]." 520 U.S. at 812-13. *DeBuono* underscored that the "historic police powers of the state include the regulation of matters of health and safety" over which the Court presumed there would be no federal preemption. *Id.* at 813.

Travelers, *Dillingham* and *DeBuono* stress that there is a heavy presumption against preemption of state laws regulating health and safety. Because the Illinois independent review law operates in two areas of traditional state regulation — health care and insurance — the Court should presume that Congress did not intend for ERISA to supplant that law. Moreover, the Illinois independent review law neither refers to nor has a significant connection with ERISA plans because the law applies *only* to HMO insurers, not ERISA plans. Therefore, applying the Court's general preemption analysis, the Illinois law is not preempted by ERISA.

Employers may or may not elect to purchase the insurance coverage provided by Illinois HMOs in order to pay for health benefits for their employees through their employee welfare benefit plans. The Illinois independent review law regulates the provision of HMO insurance and not ERISA plans. The law's requirements fall on insurers to provide independent review and insurance coverage in the event medical necessity is found, and "do not have anything to do with employee benefit plans in particular." *See Washington Physician Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1044-45 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999) (the fact that state's alternative provider statute regulates a product that ERISA plans often choose to buy by requiring HMOs to cover alternative medical treatments such

as acupuncture does not mean that it "relates to" an ERISA plan; "the [state statute] does not require employers to provide any particular welfare benefit to employees, and it does not impose any burden on the plan in administering any benefits it chooses to provide. All of these burdens fall on the health carrier.")

Nor does the independent review law have a "significant connection with" the administration of employee benefits, such as to require ERISA preemption. It has no such connection because it does not dictate the choices an ERISA plan may make. Preemption does not occur if the state law has only a remote or peripheral connection with covered plans, as in the case with many laws of general applicability. *Travelers*, 514 U.S. at 661 (citations omitted). For example, state licensing of doctors within an HMO imposes certain indirect limitations on ERISA plans. As a consequence of such state regulations, ERISA plans cannot legally purchase HMO services that provide unlicensed health care treatment. Similarly, such state laws may restrict the activities of physicians who may practice with HMOs under state registration and regulatory requirements. But those restrictions do not bind the ERISA plan — they bind doctors and the HMOs who employ them. *See State Bd. of Registration For The Healing Arts v. Fallon*, 412 S.W.3d 474 (Mo. 2001), *cert. denied*, 2001 U.S. LEXIS 9987, 70 U.S.L.W. 3315 (October 29, 2001) (state administrative physician registration and review requirements not preempted by ERISA). So it is with the Illinois independent review law. If the law is followed, the independent reviewer's determination as to medical necessity is binding on the insuring entity, the HMO, but the statute does not compel an ERISA plan to do anything. Rather, once independent review determines a procedure is "medically necessary," that procedure becomes one for which a state can require the HMO insurer to pay under state health and insurance law.

III. The Independent Review Law Regulates Insurance and Is Saved From Preemption In Any Event.

In *UNUM*, the Court reaffirmed the analysis used to resolve whether a state law "regulates insurance" within the meaning of the saving clause. First, it determines whether, from a common-sense view of the matter, the contested law regulates insurance. Second, it considers the three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act: (1) whether the practice transfers or spreads risk; (2) whether it is an integral part of the insurer-insured understanding; and (3) whether the practice is limited to entities within the insurance industry. *UNUM*, 526 U.S. at 367-68. As was true of the state law in *UNUM*, the Illinois law regulates insurance as a matter of common sense and meets at least two of the three McCarran-Ferguson factors. Therefore, it regulates insurance under the saving clause.

A. The independent review law is a state insurance law.

1. The Illinois law regulates insurance as a matter of common sense.

The Illinois law "regulates insurance" as a matter of common sense. It controls the terms of the insurance relationship by requiring the insurer to provide independent review when there is a medical necessity dispute. The law, by its very terms, is directed specifically at the insurance industry and is applicable only to HMO insurance contracts. The rule is a regulation that hones in on the insurance industry and does not just have an impact on that industry (*UNUM*, 526 U.S. at 368), "because the law is directed at the HMO industry as insurers." Pet. App. 17a.[10]

10. This Court has stated that it does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM*, 526 U.S. at 367 (citing *Runyon v. McCrary*, (Cont'd)

The Seventh Circuit's decision on this point squares with other decisions by that court and the Illinois Supreme Court which make clear that HMOs are insurers under Illinois law. *See Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994) ("because HMOs spread risk — both across patients and over time for any given person — they are insurance vehicles under Illinois law"); *In re Medcare HMO*, 998 F.2d 436, 444-46 (7th Cir. 1993) (HMOs are "substantial equivalents" of insurance companies); *Petrovich v. SHARE Health Plan of Illinois, Inc.*, 188 Ill. 2d 17, 719 N.E.2d 756, 763 (Ill. 1999) (Illinois Supreme Court describes HMOs and other managed care organizations as having "stepped into the insurers' shoes").[11]

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427 U.S. 160, 181-182 (1976)). Amicus claims that this principle "applies only where the 'district court and court of appeals have concurred' on the state law's meaning, which is not the case here." Amicus Br. at 26 n.12. As *UNUM* itself demonstrates, that is simply not the case. In *UNUM*, this Court left undisturbed the Ninth Circuit's interpretation of California's notice-prejudice rule despite the fact that the appellate court reversed the district court's grant of summary judgment in favor of *UNUM*. The district court had held that the rule did not regulate the business of insurance and was therefore preempted. *Ward v. Mgmt. Analysis Co.*, No. CV-1454H (AJB) 1995 U.S. Dist. LEXIS 21995 (S.D. Cal., August 8, 1995).

11. That conclusion is buttressed by the numerous decisions by other courts holding that HMOs are insurers. *Gregoire*, 147 F.3d at 1045-46 ("The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, but this is a distinction without a difference. In the end, HMOs function the same way as a traditional health insurer. The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.") (internal citation omitted); *see also Express Scripts, Inc. v. Wenzel*, 262 F.3d 829, 835 (8th Cir. 2001); (Cont'd)

In *Pegram v. Herdrich*, 530 U.S. 211(2000), this Court described the evolution from traditional fee for service insurance to HMOs, and recognized that HMOs are risk-bearing organizations that function much like traditional insurers. Therefore, a law that "regulates HMOs" regulates insurance from a common sense perspective. The Seventh Circuit also ruled that the HMO Act regulates insurance under a common sense understanding because the Act goes to the core of the relationship between the insurer and the insured. This is because insurance law provides that valid statutory provisions become part of all contracts of insurance to which they are applicable as if actually incorporated therein. Pet. App. 17a.

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Kentucky Ass'n of Health Plans, Inc. v. Nichols, 227 F.3d 352, 364-65 (6th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3646 (U.S. March 22, 2001) (No. 00-1471); *Corporate Health Ins. Inc. v. Texas Dep't. of Ins.*, 215 F.3d 526, 538 (5th Cir. 2000), *further opinion* on *petition for reh'g*, 220 F.3d 641 (5th Cir., 2001), *petition for cert. filed, sub nom., Montemayor v. Corporate Health Ins., Inc.* 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665); *Garofalo v. Empire Blue Cross and Blue Shield*, 67 F. Supp. 2d 343, 352 (S.D.N.Y. 1999) (statute saved as applied to HMOs to the extent they acted as insurers); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 50 (D. Mass. 1997); *Cellilli v. Cellilli*, 939 F. Supp. 72 (D. Mass. 1996); *In re Beacon Health, Inc.*, 105 B.R. 178, 186-187 (Bankr. D.N.H. 1989) ("The HMO is simply an insurance company covering its obligation to protect subscribers against medical care charges in excess of the premium collected from them by providing the services directly in kind, or indirectly through contract physicians, rather than after-the-fact reimbursing in cash for charges paid directly by the subscriber elsewhere."); *Health Plan v. Citizens Ins. Co.*, 673 F. Supp. 903 (W.D. Mich. 1987); *cf. Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 504 (4th Cir. 1993) (holding that law regulating PPOs regulated insurance).

The conclusion that an HMO is an "insurer" and therefore that Section 4-10 "regulates insurance" within the meaning of ERISA's saving clause is reinforced by other federal laws addressing HMOs. For example, the Health Maintenance Organization Act of 1973, Public Law 93-222, 42 U.S.C. § 300e ("HMO Act"), enacted on December 29, 1973 by the same Congress which enacted ERISA, provided for the formation of federally qualified HMOs. Two facets of the HMO Act support Moran's position.

First, according to the HMO Act, federally qualified HMOs are obligated to assume financial risks for the provision of health care services to their members. *See* 42 U.S.C. § 300e. In return for a fixed, prepaid, and uniform payment, an enrollee in an HMO shifts the risk of at least the cost of his or her basic health services to the HMO. That risk is spread throughout the HMO via a "community rating system." Except for certain enumerated exceptions, "an HMO is required to assume the full financial risk of providing basic health services to its members, on a prospective basis, without the benefit of reinsurance." *See* Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, S. Rpt. No. 14, at 4 (Feb. 1974) ("HMO Act Conference Report"); 42 U.S.C. § 300e(c)(2).

Second, the HMO Act, as enacted in 1973, was specific about the "restrictive provisions" of state laws which it preempted. These laws were specifically delimited and included laws which "[directed] the HMO to meet requirements as an insurer of health care services in that state regarding initial capitalization and the establishment of financial reserves." HMO Act Conference Report at 12. Had Congress intended to preempt a State's ability to "direct the HMO to meet requirements as an insurer of health care services" in every respect, not simply with regard to its initial capitalization and the establishment of financial reserves, it

would have been easy to say so. The fact that Congress specifically identified the areas in which contrary state law would be preempted reinforces the notion (supported further by the McCarran-Ferguson Act) that, apart from these areas, States remained free to include HMOs in their traditional regulation of insurers.

2. The Illinois law meets the McCarran-Ferguson factors.

The Seventh Circuit ruled, in accordance with *UNUM*, 526 U.S. at 375 n.5, that "when a law mandates a contract term between parties, whether that term is characterized as creating a procedural or substantive right, that law is integral to the insurer/insured relationship." Pet. App.17a-18a. Thus, the law meets at least two of the McCarran-Ferguson factors because: (1) it is an integral part of the policy relationship; and (2) it is limited to entities within the insurance industry. While the third factor — the transfer or spread of risk — is not required under *UNUM* (526 U.S. 373) to determine the Illinois law "regulates insurance," the law also satisfies that factor.

The independent review law does operate in individual circumstances, as with any insurance coverage determination. If coverage is found under this law, however, it operates to transfer or spread risk to all policyholders. In this respect, it acts on an individual basis just like the state notice-prejudice rule this Court concluded was not preempted in *UNUM*. The position of the United States as amicus in *UNUM* was that the notice-prejudice rule operated to spread risk. 526 U.S. at 374. *See also United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 503-504 (1993) (in holding that the actual performance of a contract constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act, the Court notes that "without performance of the terms of the insurance policy, there is no risk transfer at all.")

In the ERISA context, there is no difference between HMOs and traditional insurers regarding the risk insured in relation to the plan. From the perspective of a plan, both an HMO and a traditional insurer are available to "insure" its risks. In either case, the plan or plan sponsor contracts with the provider for certain agreed-upon healthcare coverage for the plan participants and beneficiaries in exchange for a negotiated price. If the demand for medical services exceeds expectations, the realized loss is borne by the provider, whether an HMO or traditional insurer. Likewise, the risk that one or more participants or beneficiaries will incur extraordinary costs is spread among the entire group covered under the plan.

Rush and its amicus devote substantial space in their briefs to arguing that, because Section 4-10 appears to encompass HMOs that perform only administrative services for self-funded plans, the law is not limited to entities within the insurance industry and must be preempted. This argument proves too much and too little.

It proves too much because the Court has had no trouble finding, in similar situations, that the statute at issue was not preempted. For example, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), Massachusetts enacted a mandated-benefits statute which required certain mental health benefits to be provided by every general health-insurance policy or every benefit plan which provided hospital and surgical coverage. 471 U.S. at 729-30 n.11. On its face, the statute applied directly to benefit plans — entities obviously outside the insurance industry and protected from state insurance regulation by ERISA's "deemer" clause. The Court did not hold that the statute was preempted because it could apply directly to a plan. To the contrary, the Court held that, when applied to health insurers, the statute was saved from preemption. 471 U.S. at 758.

Similarly, the Court in *Sec. and Exchange Comm'n v. Nat'l Sec. Inc.*, 393 U.S. 453 (1969), determined that an Arizona law authorizing a state official to approve mergers of insurance companies was a law regulating the business of insurance to the extent the official acted to ensure that the merger did not "substantially reduce the security of and service to be rendered to policyholders," 393 U.S. at 462, but not when the official acted to ensure that the merger was not "inequitable to the stockholders of any insurer," *Id.* at 457.

The contention also proves too little because, even assuming that Section 4-10 would raise preemption questions if applied to an HMO which provided only administrative services for self-insured plans, that simply is not the case here. It is undisputed that the plan at issue is fully insured. As such, the "administrative-services-only" argument is a straw man that has no bearing on the case before the Court.

B. The Illinois law regulates the insurer, not the plan.

This case falls squarely within the Court's decisions in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), finding that a state may indirectly regulate ERISA plans by direct regulation of their insurers, and *Metropolitan Life*, 471 U.S. 724 (1985), finding exempt from ERISA preemption a mandated-benefit law requiring insurance companies to provide minimum mental health benefits. The only difference here is that "medical necessity" (and hence insurance coverage) is determined on a case-by-case basis, rather than across the board as in *Metropolitan Life*.[12]

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12. Indeed, viewed in this context, Section 4-10 is less intrusive on insurers than the mandated-benefit laws already found not preempted by this Court.

Rush claims the Illinois law changes the employer's ERISA *plan* and therefore is preempted. Pet. Br. 19. This is simply not so. Illinois law requires that an HMO insurer provide independent review via Section 4-10. If an ERISA plan purchases HMO insurance coverage in Illinois, that coverage will have, as a contract term, independent review as set forth in Section 4-10. Nothing in this scheme offends ERISA because, just like the minimum health care benefits requirements under the Massachusetts law reviewed in *Metropolitan Life*, 471 U.S. 724, and just like the notice-prejudice rule reviewed by this court in *UNUM*, 526 U.S. 358, Illinois requires insurers to provide independent review in HMO insurance policies in Illinois.

ERISA plans and plan sponsors are free to purchase or not purchase such insurance. They may self-insure. They may provide traditional, fee-for-service insurance coverage. They may provide PPO coverage. In the event they choose HMO coverage in Illinois, that coverage and that insurance contract will include an independent review provision as required by Section 4-10. The plan does not change. The plan uses an insurance product as the funding vehicle to provide plan benefits. If that insurance product is an HMO insurance plan, it will include an independent review provision. This is classic state regulation of insurance specifically exempted from ERISA preemption by Congress. This insurance law is not preempted.

C. This Court has rejected Rush's "administration," "cost" and "uniformity" arguments.

Rush repeatedly argues that Section 4-10 relates to the "administration" and affects the "uniformity" of ERISA plan benefits, and therefore should be preempted because it is inconsistent with "core" ERISA concerns. Pet. Br. 20, 25. These arguments were rejected by this Court in *UNUM*:

> We reject UNUM's suggestion that because the notice-prejudice rule regulates only the

> administration of insurance policies, not their substantive terms, it cannot be an integral part of the policy relationship. *See*, *Metropolitan Life*, 471 U.S. at 728 n.2 (including laws regulating claims practices and requiring grace periods in catalogs of state laws that regulate insurance).

UNUM, 526 U.S. at 375 n.5. The Court also stated:

> The notice-prejudice rule serves as an "integral part of the policy relationship between the insurer and the insured." *See Metropolitan Life*, 471 U.S. at 743. California's rule changes the bargain between insurer and insured; it "effectively creates a mandatory contract term" that requires the insured to prove prejudice before enforcing a time limits of claim provision.

UNUM, 526 U.S. at 374; *see also Metropolitan Life*, 471 U.S. at 747 ("we also are aware that applicants' construction of the statute would eliminate some of the disuniformities currently facing national plans that entered into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to 'save' local insurance regulations. Arguments as to the wisdom of these policy choices must be directed at Congress."). As in *UNUM*, the Illinois HMO Act also "effectively creates a mandatory contract term" that requires the insurer to provide independent review of the disputed medical necessity decision. *UNUM*, 526 U.S. at 374; *Plumb v. Fuller Pump Serv.*, 124 F.3d 849, 859 (7th Cir. 1997). Rush ignores this rule of law in its brief. Analytically, there is no reasonable distinction to be made among a state mandatory-insurance benefit law, an anti-subrogation rule and a notice-prejudice requirement (each of which this Court has found not

preempted) and the independent review requirement here.[13] Each kind of mandate must be viewed as a matter of state insurance law which has been incorporated into the terms of the insurance purchased by plans in that state; none of these state mandates "conflict[s] with a substantive provision of ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987).

The cases where the Court has upheld the "administration" argument do not support Rush because they involved direct ERISA plan regulation. *Fort Halifax Packing Co. v. Coyne*, 428 U.S. 1 (1987), for example, makes the distinction between burdens imposed on plans versus administrative burdens on plan benefits. 482 U.S. at 911 ("Congress preempted state laws relating to plans, rather than simply to benefits . . . the Maine statute neither establishes nor requires an employer to maintain an employee benefit plan."); *see also FMC Corp.*, 498 U.S. at 52, 60 (Pennsylvania anti-subrogation statute preempted because it acted directly on ERISA plans; indirect regulation of plan by regulation of its insurer permissible).

Rush and its amicus advance policy arguments based on cost and uniformity so that insurance costs (and apparently thereby employer costs via the purchase of such insurance) are controlled. Rush relies on the dissent on denial of rehearing in *Moran* to support this assertion "[that] the Illinois law will shrink benefits and deter some employees from offering health insurance at all." Pet Br. 30. This Court has repeatedly said a "cost" effect on an insurer will not defeat the operation of the saving clause. *Travelers*, 514 U.S. at 657 ("an indirect economic influence, however, does not bind

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13. In *UNUM*, the Court found that the state notice-prejudice rule did not conflict with ERISA § 503's notice and claim review requirement because "by allowing a longer period to file than the *minimum* filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations." 526 U.S. at 377 (emphasis original).

plan administrators and thus function as a regulation of ERISA plan itself."); *DeBuono*, 520 U.S. at 816 ("any state [law] . . . that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute."). Thus, this cost argument is baseless because cost is irrelevant to determining whether a law regulates insurance with the meaning of ERISA's saving clause. For example, mandated benefit laws add costs to the plans that choose to purchase insurance rather than self-insure, but that fact did not prevent this Court from deciding in *Metropolitan Life* that the Massachusetts mental health law regulated insurance within the meaning of the saving clause. Similarly, procedural protections like the notice-prejudice rule at issue in *UNUM* add costs by causing claims to be paid that would otherwise be denied. A law mandating independent review is no different.

Rush's cost argument is also premised on the fallacy that only insurance companies incur costs and expenses in providing employee benefits such as health insurance. That is not true; both employers and insured employees incur costs. Specifically, an employee contracts with an employer to exchange her labor for salary and benefits. The employees earn the benefits for which they have contracted and often pay a part of the premium. Rush and its amicus cannot take those earned benefits away by arguing a "policy" that they do so to reduce costs. Debra Moran and her husband earned coverage for necessary medical procedures. If that means that Rush incurs increased costs because it must provide independent review about medical necessity, that was part of the bargain Rush made, and it was part of the benefit Paul and Debra Moran earned. ERISA was never meant to take that away.

Rush's uniformity argument similarly fails because this Court has repeatedly held the absence of uniformity is a necessary consequence of ERISA's saving clause and, therefore, will not defeat its enforcement:

> As we have pointed out . . . the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans. . . . Our interpretation of the deemer clause makes clear that if a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contract; if the plan is uninsured, the state may not regulate it. As a result, employers will not face "conflicting or inconsistent state and local regulation of employee benefit plans."

FMC Corp., 498 U.S. at 64; *see also UNUM*, 526 U.S. at 376 n.6 ("we recognize that applying the States' varying insurance regulations creates disuniformities for 'national plans that enter into local markets to purchase insurance.' *Metropolitan Life*, 471 U.S. at 747. As we have observed, however, 'such disuniformities . . . are the inevitable result of the Congressional decision' to save local insurance regulation.' *Ibid.*")

Rush closes its brief with its cost argument, complaining of "[c]hanges in the industry," "[p]oorly drafted laws" and "a blurring of pertinent distinctions in . . . health insurance," Pet. Br. 43, and implicitly inviting the Court to rewrite the law so as to conform to Rush's view of wise healthcare policy. The invitation should be declined.

First, it is historically inaccurate to imply that industry "changes" have created circumstances the Congress that enacted ERISA could not have foreseen (*i.e.*, HMOs rather than traditional fee-for-service health insurance). The Federal HMO Act was passed in 1973, a year before ERISA. 42 U.S.C. § 300e.

Thus, Congress certainly knew about HMO insurers when it passed ERISA. Had it wanted to exclude from the "expansive" scope of ERISA's saving clause remedial legislation regulating HMOs under state insurance laws, it could easily have done so.

Second, Rush's view of wise policy is not even shared by other members of its industry. One of its supporting amicus, AAHP, has published multiple reports this year extolling independent medical reviews as "successful" and "empowering consumers with solutions." *See* AAHP, "Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions," (April, 2001); and AAHP Report, "Health Plan Liability: What You Need to Know" at 11-12 (March, 2001).[14]

Third, even where a changing industry has created difficulties not foreseen by Congress, the appropriate response is not for courts to recast the substance of a statute in the guise of interpreting it. This Court so held in a case that did involve a fundamentally changed industry — specifically, a growing number of so-called "nonbank banks" being set up outside the control of the Federal Reserve Board. *Board of Governors v. Dimension Fin. Corp.*, 474 U.S. 361 (1986). Holding that the administrative agency had no authority outside the scope of the existing legislation to regulate these new entities, the Court explained:

> If the Bank Holding Company Act falls short of providing safeguards desirable or necessary to protect the public interest, that is a problem for Congress, and not the Board or the courts, to address.

Id. at 374.

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14. Both publications are available online at www.aahp.org.

IV. The Illinois Law Does Not Conflict With ERISA.

Rush argues that if the Illinois law is saved by the saving clause from ERISA it is still preempted because it somehow violates ERISA and its enforcement scheme. Pet. Br. 19. This argument fails because the Illinois law does not conflict with 29 U.S.C. §§ 1132 or 1133.

A. ERISA permits States to complement its claims procedures.

Rush's "conflict" argument fails in the first instance because it would mean ERISA plan sponsors could not voluntarily provide for independent review, nor could insurance policies they elect to purchase. No one believes this is true.[15]

Moreover, Rush's conflict argument is directly contradicted by ERISA and its enabling regulations. 29 U.S.C. § 1022, entitled "summary plan description," sets forth the requirement that a plan provide such a description and specifies the information that shall be included. It provides in relevant part:

> (b) the summary plan description shall contain the following information:
>
> . . . .

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15. Actual practice reveals the opposite. A number of prominent national health insurers have agreed to provide independent outside review of medical necessity. *See, e.g.*, New York Times, 1/13/99, "Aetna to Allow Outside Reviews of Care Denials." (Appendix M to Moran's 7th Circuit brief); and Managed Care Reporter, July 28, 1999, "United Health Care Launches External Appeals Process For Coverage Decisions." (Appendix N to Moran's 7th Circuit brief). Indeed, Rush's own amicus in this Court, the American Association of Health Plans itself, urged the HMO industry to voluntarily let patients who are denied care appeal to outside experts. (Chicago Daily Law Bulletin, February 23, 1999, "Health Maintenance Trade Group Urges External Reviews").

> The procedures to be followed in presenting claims for benefits under the plan . . . and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under § 1133 of this title).

29 U.S.C. § 1022(b). Section 1133 sets forth the "claims procedure" that a plan must provide. It is a basic maxim of statutory construction that statutes are to be read to give all of their language effect, and where two sections may conflict, they are to be read if possible to give effect to both. *Walters v. Metropolitan Educ. Enter. Inc.*, 519 U.S. 202, 209 (1997); *Bailey v. United States*, 516 U.S. 137, 145 (1995); and *In re Colonial Realty Co.*, 980 F.2d 125, 132 (2d Cir. 1992). Here, the statutes can be read to give effect to both. Section 1133 provides only the ***minimum*** requirements for plan claims procedures. Section 1022's provision that the summary plan description contain the procedures for presenting claims "including procedures required under Section 1133" means a plan may provide additional procedures to those of Section 1133. Under Rush's view, however, ERISA's enforcement mechanisms are exclusive, thereby barring Illinois from requiring insurers to provide additional claims procedures to those in Section 1133 where those insurers happen to insure an ERISA plan benefit and, consequently barring plan sponsors from providing such procedures voluntarily. That reading makes the language in § 1022 meaningless, which is contrary to law. This result is avoided if ERISA is construed to mean plan sponsors and States can add procedural requirements to ERISA's basic claims procedures, which can be enforced consistent with *Pilot Life*, under ERISA's enforcement provision, 29 U.S.C. § 1132(a).

The States' ability to supplement ERISA's claims procedures is confirmed by the applicable regulations.

29 C.F.R. § 2560.503.1, entitled "Claims Procedure," provides in relevant part:

> A. Scope and Purpose. This section sets out certain ***minimum*** requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits. . . .

(emphasis added). If the requirements are only "minimums," who can expand on them and add additional complementary requirements? Certainly, the plan sponsor, either directly in the plan or by funding the plan through the purchase of an insurance policy that contains such provisions. Pursuant to the plain language of the saving clause, state regulators can too. This is confirmed by 29 C.F.R. § 2560.503.1(c), which provides in relevant part:

> C. The claims procedure for an insured welfare or pension plan. (1) to the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more states, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with a notice of decision by such company, service or organization.

Again, the language in this regulation is permissive and minimal: "may." Further, it specifically references insurance "subject to regulation under insurance law of one or more states." There would be no reason to say "may" or to reference such state regulation if it did not apply and if such insurance laws could not provide additional claims procedures. *See also* 29 C.F.R. § 2560.503-1(g) (describing review procedures, which shall "include but not be limited to" certain elements).

While Rush argues that a finding that Section 4-10 is preempted is consistent with the Department of Labor's new regulations (Pet. Br. 32 n.11), the exact opposite is true. The new regulations provide that "nothing in this section shall be construed to supersede any provision of state law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section," 29 C.F.R. § 2560.503-1(K)1, and specifically provide that state external review procedures do not prevent such applications. *See* 29 C.F.R. § 2560.503-1(K)2 ("a state law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such state law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing").[16]

As is always so at any stage of any claim procedure, if a beneficiary prevails under independent review, the claims process is finished and the beneficiary receives the claimed benefit. But nothing in the Illinois law precludes further action under a claims procedure (*e.g.*, appeal to a plan fiduciary) or a

16. ERISA, on its face, gives the Department of Labor authority to promulgate regulations about claims procedure. 29 U.S.C. § 1135. Even if the statute itself was not clear, these regulations confirm States can add provisions to ERISA's claims procedures, including external review. *See Bragdon v. Abbott*, 524 U.S. 624, 642 (1998) (the well-reasoned views of the agencies implementing a statute constitute a body of experienced and informed judgment to which courts and litigants may properly resort for guidance); *United States v. Mead Corp.*, 121 S. Ct. 2164, 2171, 150 L. Ed. 2d 292 (June 18, 2001) (administrative implementation of a statutory provision where that agency has authority to regulate is entitled to *Chevron* deference; considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer).

lawsuit under Section 1132 if the claim is denied under independent review.[17] The court of appeals concluded that "thus, a suit by [Moran] to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan; precisely the sort of suit that is contemplated by Section 502(a)(1)(B) 'to enforce rights' and to 'recover benefits' under the plan." Pet. App. 21a. The Seventh Circuit unanimously ruled that the HMO Act:

> requires entities in the business of insurance to provide additional safeguards to preserve the integrity of the decision making process. Following the example of the Supreme Court of the United States, we believe that such requirements ought to be treated as mandated contract terms and treated as part of the insurance contract. *See Ward*, 526 U.S. at 375-76; *see also Plumb*, 124 F.3d at 861.

Pet. App. 3a. The United States Department of Labor, the public agency responsible for interpreting and enforcing ERISA, agrees, as it asserted as amicus below that the Illinois independent review statute is not preempted, but is saved from preemption by the saving clause, and should be permitted to be enforced by ERISA. The Department of Labor argued that Section 4-10 created a mandatory contract term just like in *UNUM* that could be enforced via Section 502(a). Department of Labor, Seventh Circuit Amicus Br., pp. 8, 14, 18.[18]

17. An employee who is the beneficiary of an insured plan benefit can use Section 1132 to force the carrier to implement the administrative process such as independent review, where the carrier refuses to provide it. *E.g.*, *Flacche v. Sun Life Assurance Co.*, 958 F.2d 730, 733 (6th Cir. 1992) (§ 1132 claim may be based upon any violations of ERISA or terms of the plan).

18. Rush's argument that Section 4-10 would result in federal courts simply "rubber stamping" independent review decisions (Pet. Br. 25 n.6) is baseless, as the federal court will have the same

(Cont'd)

In *UNUM*, the Court noted that the state notice-prejudice statute before it serves to "compliment, rather than contradict ERISA and the regulations" and therefore was not preempted. 526 U.S. at 374. The Court has also noted that:

> [By] saving such insurance regulation from preemption, ERISA "leaves room for complementary or dual federal and state regulation" of the insurance industry.

John Hancock Mut. Life Ins. Co. v. Harris, 510 U.S. 86, 98 (1993). The same conclusions apply here.

B. This Court's precedents confirm the absence of conflict here.

This Court gave effect to the facially unrestricted scope of the insurance saving clause in *Metropolitan Life* when it "declined to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer' clause which modifies it," and concluded that "if a state law 'regulates insurance' as mandated – benefit laws do, it is not preempted." 471 U.S. at 746; *cf. Pilot Life*, 481 U.S. at 56-57 (*Metropolitan Life* clearly "rejected any interpretation of the [insurance] saving clause . . . that saved from preemption 'only state regulations unrelated to the substantive provisions of ERISA' "). In addition, the force of the saving provision's express terms is reinforced by the Court's frequent recognition — particularly in recent cases — that ERISA preemption provisions must be read against the background of the "assumption that the historic police powers of the states were not to be superseded by the Federal

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(Cont'd)
function it always had under 29 U.S.C. § 1132. These lawsuits for erroneous denial of benefits are only brought if the claim for benefits is denied. Nothing in the Illinois law alters that.

act unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655.

The Court noted in *FMC Corp.* that the state anti-subrogation law before it "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain," (498 U.S. 61) and cited its decision in *Pilot Life*, holding:

> [The Pennsylvania statute] does not merely have an impact on the insurance industry; it is aimed at it. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 50, 95 L.Ed.2d 39, 107 S.Ct. 1549 (1987). This returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore it is not preempted.

498 U.S. at 61. The Court also explained the scope of *Pilot Life* in *FMC Corp.*: the Court did not distinguish between state substantive or remedial law, but rather stated categorically that if the law is aimed at the insurance industry, unless it is covered by the deemer clause, the law is not preempted. In other words, states can directly regulate ERISA plan insurers and thereby indirectly regulate an insured plan. States may not regulate uninsured plans. 498 U.S. at 64.

Moreover, the fact that federal and state laws are different does not mean that there is an impermissible conflict. ERISA is not absolute, but explicitly recognizes a role for state insurance regulation, thus permitting state insurance laws to supplement or complement ERISA's standards. *John Hancock*, 510 U.S. at 98. Illinois's independent review law provides an additional mechanism for determination of whether a particular claim is covered, thereby protecting Illinois insureds' rights. There is no conflict or inconsistency

with ERISA. Illinois law cannot be found to stand as an obstacle to the accomplishment and execution of Congressional purposes and objectives.[19]

This Court's decision in *John Hancock* illustrates the high burden that must be met in order to find that compliance with both federal and state laws is a physical impossibility. In *John Hancock*, this Court rejected the argument that ERISA and state insurance laws were at odds and "would pose irreconcilable conflicts between state and federal regulatory schemes" concerning the regulation of insurance general account contracts. 510 U.S. at 97. The Court held that ERISA's requirement that a fiduciary act solely in the interest of participants did not conflict with a state requirement that an insurer consider the interests of all its contract holders, creditors and shareholders. *Id.* at 97-98. Here too, an insurer may comply with both Illinois independent review law and ERISA's requirements for the processing of claims. The insurer can provide its own review of the claim in accordance with ERISA's minimum requirements. It can then provide independent review in accordance with Illinois law.

Illinois Section 4-10 does not put Illinois HMO insurers in the position of choosing whether to follow their obligations under state or federal law; they are obliged to comply with both. Because the operation of both provisions can be "harmonized," *John Hancock*, 510 U.S. at 98, Section 4-10 is not preempted by the traditional principles of conflict preemption. Section 4-10 operates as a state insurance law

19. In analyzing Congress' purposes, the Court looks not only at the stated purposes but at the structure of the statute as a whole. ERISA's declared principal purpose is to "protect plan participants and beneficiaries." 29 U.S.C. § 1001(b). The purpose of ERISA's claims procedure and its interpreting regulations is to provide minimum standards to protect participants and beneficiaries. 29 C.F.R. § 2560.503-1; Claims Procedure for Employee Benefit Claims, 42 Fed. Reg. 27,426 (1977).

applied in conjunction with — not in opposition to — ERISA's civil enforcement scheme.

C. Rush's argument about *Pilot Life* is contrary to *UNUM*.

Rush's application of *Pilot Life* to this case is contrary to the Court's most recent precedent on the issue in *UNUM*. This Court stated:

> UNUM and its amici assert that even if the notice-prejudice rule is saved under 29 U.S.C. § 1144(b)(2)(a), it is nonetheless preempted because it conflicts with substantive provisions of ERISA in three ways. UNUM first contends that the notice-prejudice rule, by altering the notice provisions of the insurance contract, conflicts with ERISA's requirement that plan fiduciaries act "in accordance with the documents and instruments governing the plan." § 1104(a)(1)(d). According to UNUM, § 1104(a) (1)(d) preempts any state law contrary to a written plan term.
>
> UNUM's "contra-plan term" argument overlooks controlling precedent and makes scant sense. We have repeatedly held that state laws mandating insurance contract terms are saved from preemption under § 1144(b)(2)(a). *See Metropolitan Life*, 471 U.S. at 758. ("Massachusetts' mandated benefit law is a law which regulates insurance and so is not preempted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA"); *FMC Corp.*, 498 U.S. at 64 ("If a plan is insured, a state may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts"). Under UNUM's interpretation of § 1104(a)(1)(d),

> however, states would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by asserting a contrary term in plan documents. This interpretation would virtually "write the savings clause out or ERISA." *Metropolitan Life*, 471 U.S. at 741.

UNUM, 526 U.S. at 375-76.

Rush advances the very theory rejected by this Court in *UNUM*, arguing that its policy gives it unlimited discretion to determine "medical necessity" and displaces the state regulation under Section 4-10, which requires independent review to determine medical necessity. According to this argument, Illinois is powerless to alter the terms of an insurance policy purchased by ERISA plans because Rush, as the insurer, displaced state regulation simply by inserting a contrary term in the plan documents. As the Court concluded in *UNUM*, this interpretation writes the saving clause out of ERISA and renders the Illinois legislature's efforts to regulate HMO insurance in Illinois ineffective, across the board, when purchased by or for ERISA plans. This is contrary not only to the intent of the Illinois legislation, but also to federal Congressional intent with respect to the saving clause. Rush's argument "pulls the teeth" of the Illinois independent review statute, because under its argument, while independent review can be required, it has no force or effect and can be disregarded by the HMO insurer, as it was here.

No ERISA law or regulation requires that a claims administrator for insurance purchased by a plan must have exclusive authority to apply and interpret the terms of the insurance. By virtue of the saving clause, the states are free to regulate insurance in this area by enacting review

provisions. The independent review law does just that. The Illinois statute is consistent with ERISA and complements its provisions in a Congressionally – approved form of dual regulation.

V. If For Any Reason The Requirements of Section 4-10 Are Not Enforceable Under 29 U.S.C. § 1132, Then They Are Enforceable under State Law.

As discussed above, the Illinois law is enforceable under 29 U.S.C. § 1132 just like any of the provisions of insurance policies purchased by plans or plan sponsors to provide plan benefits. Even if this were not true, however, it does not logically follow that the Illinois law is not enforceable at all. Rather, if Section 4-10 cannot be enforced under ERISA, then ERISA does not preempt and Section 4-10 is enforceable under state law. *See Benjamin*, 328 U.S. at 439 n.52 ("it would be a shocking thing, if state and federal governments acting together will prevent them from achieving the end desired by both, simply because of the division of power between them."); *Int'l Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 301 (6th Cir. 1991), *cert. denied*, 504 U.S. 973 (1992) (ERISA will not preempt state law claims based on wrongs for which it provides no remedy; Kentucky conversion rights statute, which was not protected or guaranteed by an ERISA remedy, was not preempted).

Extending *Pilot Life*, as Rush suggests, to preempt the enforcement of the Illinois independent review law here would lead to "quixotic" results. In *Franklin William Ins. Trust* v. *Travelers Ins. Co.*, 50 F.3d 144, 151 (2d Cir. 1995), the Second Circuit determined that ERISA did not preempt enforcement of a New York law that regulated insurance within the meaning of ERISA. There, plaintiff moved to remand a state law cause of action for damages based on the

failure of the insurance company to comply with the state insurance law which required statutory interest on untimely payments of life insurance proceeds. The Second Circuit held that removal was improper because ERISA did not preempt the New York insurance law. It explained that "it would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption . . . may nonetheless be enforced only by ERISA provisions and remedies." 50 F.3d at 151; *see also General Motors Corp. v. California State Board of Equalization*, 824 F.2d 816 (9th Cir. 1987), *cert. denied*, 485 U.S. 941 (1988) ("*Pilot Life* involves a state law of general application, one that directly conflicts with a substantive provision of ERISA. This case, in contrast, involves a state law directed specifically at the insurance industry, one that does not conflict with any of ERISA's substantive provisions.")

VI. Regardless of Preemption, Rush Voluntarily Incorporated The Illinois Independent Review Requirement Into Its Insurance Policy.

It ultimately makes no difference in this case whether the Illinois law is generally preempted or whether it is saved from preemption under ERISA's saving clause. This is because Rush's HMO insurance policy, by its express terms, voluntarily incorporates the Illinois statute as a term of the insurance coverage. Rush's Member Certificate specifically provides that:

> If the provisions of this certificate do not conform to the requirements of any state or federal law that applies to this certificate, the certificate is automatically changed to conform with the requirements of that law.

R.38, Ex. A, p. 34. Thus, Rush is obligated to provide independent medical review by the independent force of its

own insurance policy term, which "automatically change[s]" the policy to "conform with the requirements" of any state law that applies to HMO insurance coverage.

Rush buries in a footnote its only argument on this point. Pet. Br. 27-28 n.8. There, Rush advances the largely circular contention that, if ERISA preempts the Illinois statute (i.e., prevents the statute's application by force of state law), then the statute does not "apply" to the HMO policy and so (supposedly) it is not incorporated into the policy by the above-quoted provision. *Id.*, citing *Light v. Blue Cross & Blue Shield of Ala., Inc.*, 790 F.2d 1247, 1248 (5th Cir. 1986). This theory fails.

The meaning of the terms of written documents is a matter of the parties' intent. The issue in *Light* concerned an ERISA plan provision incorporating state law. 790 F.2d at 1248. Although the *Light* opinion contains no analysis, the court's theory presumably was that the ERISA plan sponsor would not have intended to incorporate into the plan all state law that would (absent preemption) apply to the plan terms that affirmatively violated ERISA's substantive requirements for benefit plans. Such interpretive reasoning is inapplicable here. The issue is not incorporation of state law by the plan sponsor into an ERISA plan, but rather an insurance company's conformance of its insurance policy to the requirements of state law. The latter has independent legal significance. As previously discussed, HMO insurance (like other health insurance) is sold to individuals and families directly and also to employee benefit plans not governed by ERISA. And even when the insurance is sold to an ERISA plan or plan sponsor, the insurance policy still is not governed exclusively by federal law (unlike the plan itself).

In the insurance situation, therefore, a policy provision incorporating state law should be interpreted in accordance

with its plain meaning. The provision here conforms the HMO policy to state law governing HMO insurance policies, and no exclusion is made for any state law that might otherwise be preempted when the insurance is sold to or for an ERISA plan. Accordingly, the Illinois independent review provision applies here by force of the terms of the HMO policy itself.

VII. If Preemption Were Found, Moran's Appeal On The Breach Of Fiduciary Duty Claim Must Be Decided.

Because the district court asserted jurisdiction on the basis of ERISA preemption, Moran filed an amended complaint with counts under ERISA for breach of contract and breach of the independent review requirement and, alternatively, for breach of fiduciary duty. Rush also obtained summary judgment in the district court on the alternative breach of fiduciary duty count, which Moran also appealed. This issue was not addressed by the Seventh Circuit because it ruled the Illinois independent review law was not preempted as a matter of law and Moran was entitled judgment on that basis.

If this Court reverses, the cause should be remanded to the Seventh Circuit to consider Moran's appeal on the breach of fiduciary duty issue. The factual record, construed most favorably to Moran, demonstrates a question of fact on the reasonableness of Rush's conduct in denying her request for coverage under all the circumstances. *See* R.58, 75-76; Moran's Statement of the Case, *supra*.

The courts of appeal have required under ERISA that insurers, when acting to determine coverage under an insurance contract purchased by an ERISA plan, "are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to insure that they

act in the best interest of the plan beneficiaries." *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998). Likewise, the Third Circuit in *Heasley v. Belden and Blake Corp.*, 2 F.3d 1249 (3d Cir. 1993), concluded:

> To avoid a conflict of interest, the organization referenced in the [ERISA] plan should be independent. Applying this principle, the Seventh Circuit refused to accord deference to an insurer's denial on an experimental procedure exclusion which defined an experimental procedure so classified by the insurer itself. Any other result, the court reasoned, would enable the insurer "to immunize itself from liability . . . simply by creating a plan which provides that it will deny claims for medical procedures if the insurer's internal advisory committees deem them experimental." *Reilly v. Blue Cross Shield*, 846 F.2d 416, 423 (7th Cir.).

2 F.3d at 1260. That is exactly what Rush has done here. It tries to immunize itself from liability by creating an insurance contract, which provides that it will deny claims for medical procedures if the insurer's administrator deems them not "medically necessary." In this context, the insurer's benefits determination is entitled to a sliding scale of lesser deference down to none, based on the extent of the conflict and the circumstances of the particular denial. *Doe v. Group Hosp. and Med. Serv.*, 3 F.3d 80, 87 (4th Cir. 1993); *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556, 1568 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) (burden shifts to conflicted insurer to show independent basis for coverage decision; degree of deference "significantly diminished"). Further, no case has held as Rush claims (Br. 13) that the benefits determination of an insurer of an ERISA benefit must be reviewed under an arbitrary and

capricious standard. *Southern Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 100 (5th Cir. 1997) (ERISA does not dictate a standard of review of medical necessity decisions).

CONCLUSION

The judgment should be affirmed.

Respectfully submitted,

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